AUDIT COMMITTEE

Tuesday 22 January 2002
(*Afternoon*)

Session 1

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CONTENTS

Tuesday 22 January 2002

AUDIT COMMITTEE
2nd Meeting 2002, Session 1

CONVENER

*Mr Andrew Welsh (Angus) (SNP)

DEPUTY CONVENER

*Mr David Davidson (North-East Scotland) (Con)

COMMITTEE MEMBERS

Scott Barrie (Dunfermline West) (Lab)
*Margaret Jamieson (Kilmarnock and Loudoun) (Lab)
*Paul Martin (Glasgow Springburn) (Lab)
*Mr Lloyd Quinan (West of Scotland) (SNP)
*Mr Keith Raffan (Mid Scotland and Fife) (LD)

*attended

WITNESSES

Mr John Aldridge (Scottish Executive Health Department)
Mr Trevor Jones (Scottish Executive Health Department/Chief Executive of the National Health Service in Scotland)

CLERK TO THE COMMITTEE

David McGill

SENIOR ASSISTANT CLERK

Ruth Cooper

ASSISTANT CLERK

Seán Wixted

LOCATION

The Chamber

Scottish Parliament

Audit Committee

Tuesday 22 January 2002

(*Afternoon*)

[THE CONVENER *opened the meeting at 14:01*]

The Convener (Mr Andrew Welsh): I welcome members to the second meeting in 2002 of the Audit Committee. I have received apologies only from Scott Barrie. I make my usual announcement about mobile phones and pagers—I hope that they are all switched off.

Items in Private

The Convener: Item 1 is to decide whether to take various items in private. First, the committee is asked whether items 2 and 4 should be taken in private. Item 2 is the consideration of lines of questioning of today's witnesses. Item 4 is consideration of the evidence taken once the witness session is complete. Do we agree to take those items in private?

Members *indicated agreement*.

The Convener: Secondly, as we decided at our last meeting, there will be two further evidence-taking sessions in relation to the national health service inquiry. The committee is asked to consider whether it should take items dealing with lines of questioning and consideration of evidence at those meetings in private. Doing so should contribute to the smooth running of those meetings. Are we agreed so to do?

Members *indicated agreement*.

The Convener: I stress that those items are specifically matters of internal housekeeping and their content will be made public during the following stages of the inquiry. We now move into private.

14:03

Meeting continued in private.

14:11

Meeting continued in public.

"Overview of the National Health Service in Scotland 2000/01"

The Convener: I welcome the witnesses and members of the public to the meeting.

We will be taking evidence on the Auditor General's report "Overview of the National Health Service in Scotland 2000/01". We will take evidence from Mr Trevor Jones, who is the chief executive of the NHS in Scotland and head of the Scottish Executive health department. He is accompanied by Mr John Aldridge, who is the director of finance in the health department.

I understand that the facts in the report have been agreed. Is that correct?

Mr Trevor Jones (Scottish Executive Health Department/Chief Executive of the National Health Service in Scotland): That is correct.

The Convener: The committee has received correspondence from you, commenting on some of the issues that are highlighted in the Auditor General's report. Today we will examine financial stewardship in the NHS in Scotland, based on the Auditor General's report. We will examine three main areas relating to the financial performance of the NHS in Scotland as seen from the health department's point of view. First, we will consider the financial performance of NHS trusts. Secondly, we will consider the impact on the health service of the £90 million additional funding for the NHS that was announced by the Minister for Health and Community Care in September 2001. Lastly, we will consider the progress on the steps being taken to secure a more comprehensive picture of the financial position in the new NHS board areas, and within the NHS in Scotland overall.

I will open the session by asking Mr Jones two general questions.

The 2000-01 report is the second report to be published on the NHS in Scotland. This time last year, you gave us your views on the overall financial performance of the NHS. You highlighted the fact that last year was not a typical year because it followed major structural change in the service and contained year 2000 risks. Was 2000-01 a more typical year? How satisfied are you with the overall financial performance of the NHS in 2000-01?

Mr Jones: It is fair to say that 2000-01 was a typical year, although we are in the process of implementing new financial control procedures for the NHS following the introduction of new NHS boards. We might touch on that point later.

I am satisfied with the NHS performance in that year. I was reassured that the Auditor General concluded that financial stewardship continued to be of a high standard. None of the 51 NHS bodies had qualifications in their accounts and, again, the Auditor General reassured us that the key financial systems were of a good standard.

Overall, the 15 NHS boards all lived within their cash limits. Apart from two very minor overspendings, the special health boards lived within their cash limits. Collectively, NHS trusts were within £1.7 million of break-even in 2000-01, which represents 0.03 per cent of a budget of almost £5 billion. Overall, financial performance was good. Some matters concerned us, and the Auditor General has identified issues in some trusts. Members will no doubt pick that up as the meeting progresses.

The Convener: Will you assure us that your department knows the exact overall financial situation in the NHS boards and trusts?

Mr Jones: Our monitoring arrangements are tighter than they were a year ago. We are developing the new performance assessment framework, which we discussed last year. That will come into effect on 1 April and will improve further our monitoring of overall performance and not simply financial performance.

14:15

The Convener: In other words, the system has settled and you have established a base norm that will allow comparison in the future.

Mr Jones: That is correct.

The Convener: We established last year that NHS trusts face challenges in meeting both their health care commitments and the financial targets that the health department sets. How is the implementation of the new unified boards under the health plan intended to address that problem?

Mr Jones: Mr Aldridge may wish to discuss some of the detailed changes in the financial regime. At a strategic level, we are considering the overall financial performance of NHS systems—for example, the performance in greater Glasgow—rather than focusing on the performance of particular organisations. We expect collaborative working among all the agencies in an area, to ensure that patients have maximum benefit for the amount of investment that is being made in each area. That has strengthened significantly how we manage resources in the NHS.

Trust chief executives and chairmen are now corporate members of the NHS board with corporate responsibility for the overall performance in an area. That helps financial systems too. John Aldridge will describe some of the detailed financial changes that will improve the system.

Mr John Aldridge (Scottish Executive Health Department): I start by repeating a comment that Trevor Jones made. The new structure of NHS boards means that the various NHS organisations in an area co-operate more. A past feature was the attempt to look after each organisation's own interest, rather than to look for the collective good. Evidence from many parts of Scotland shows that the situation is already improving.

As for the financial regime, in the financial year 2001-02, health boards' resources are being controlled on a resource basis rather than a cash basis. A difficulty in obtaining an overall picture used to be that trusts were controlled on a resource basis, whereas health boards were controlled on a cash basis—it was difficult to make the read-across. The situation will improve this financial year, as both sets of organisations are being controlled on the same basis.

For the financial year from April 2002, a further step forward will be taken when we introduce our new financial regime. We will expect the monitoring returns from NHS board areas to take the form of a consolidated report each month, which will bring together the position of all the organisations in the area. However, as long as NHS trusts continue to be statutory bodies, we will continue to take an interest in the activity and the performance of the individual bodies. The key measure will be how the system as a whole performs locally.

The Convener: How do you set overall realistic health care targets for boards and trusts if they are not integrally linked with financial targets? Is a funding gap inevitable, or are care targets and finance targets in harmony?

Mr Jones: As I said, the financial performance in the year under audit shows that NHS boards were within control levels and lived within their cash limits. If we allow for the technical deficit in Lanarkshire, which was simply a consequence of an adjustment to the assets in the trust and was not part of the financial performance, the overall net position is that trusts were within £1.7 million of break-even on a budget of £5 billion.

In 2000-01, the finances were in harmony. That does not mean to say that we are complacent about the pressures that the NHS faces. We expect the new NHS boards to be vigilant and to develop long-term financial plans to ensure that their activities can be delivered within the available resources. That is part of the new monitoring arrangements and the new local health plans that we are due to receive from all the NHS boards by the end of this month.

The Convener: That was covered by your letter. You talk about a net deficit. You say that the budget was very nearly in balance—the net deficit is less than £2 million. However, I notice that the deficits are all in the acute sector. They are counterbalanced by surpluses in the primary care sector. The position in the acute sector is much worse than it appears in your letter. You are comparing the rise in the deficit with the rise in the surpluses in one year, but what about cumulative deficits? You might be able to present a rosy picture for one year, but that might disguise cumulative problems later.

Mr Jones: As we said, we want the NHS boards to manage the overall resources in an area. It is not sensible for one part of the NHS system to underspend while another part overspends. We expect the NHS boards to consider the overall financial situation in an area. We allocate resources; the NHS boards must decide how the resources are allocated between acute and primary care services.

Our clear policy is that we should invest more in primary care services, because we believe that through that mechanism we will be able to treat more patients in the community, which will lift some of the pressure on the acute sector. Obviously, that will have a lead-in time. Some of the investment needs to be put in place in primary care first, before the knock-on effect is felt in the acute sector. We want the NHS boards to manage the overall financial situation.

The Convener: Are you sure that health care targets are matched to the resources of the acute trusts? Is there an imbalance and thus a future recurring problem?

Mr Jones: The in-year position shows that there are deficits in some acute trusts. The deficits are relatively low in percentage terms, but significant in cash terms, because of the sheer size of the business. The percentages are given in exhibit 5 in paragraph 4.6 of the report.

In some areas, we need to continue the reviews of acute services. Acute service reviews are taking place in several areas of Scotland. We must ensure that services are provided within the available resources.

Mr David Davidson (North-East Scotland) (Con): You talked about boards being responsible for health activities in their areas. You seem to regard the trusts—whether primary or acute—as being merely a part of that. Why then did acute trusts—particularly the teaching trusts—have to agree deficits with your department and not merely with their health board?

Mr Jones: You will recall that we are in transition. The new NHS boards started in September 2001. The new financial regime comes in from 1 April 2002. We are in transition. In the year under audit, trusts and health boards were directly accountable to the Executive. Since the formation of the NHS boards, we have been much clearer about expecting the NHS board to be the strategic body. The trust chairmen and chief executives are corporate members of those boards. That did not apply in the year under audit.

Mr Davidson: I understand what you say. It is important to examine the background when we have got you with us.

Are you content that the move to the new system will have the transparency that is required to allow people to understand the tensions within a board structure?

Mr Jones: That is critical—it is the test of the new system.

Mr Keith Raffan (Mid Scotland and Fife) (LD): You mentioned the need for greater investment in the primary care side to take the pressure off the acute side. In paragraph 4.7 of his report, the Auditor General mentions

"increasing demands on community services"

as one of those pressures. Basically, you are moving pressures from the acute to the primary side. I presume that you think that primary care, with its surpluses, is more capable of absorbing those pressures. Is that roughly right?

Mr Jones: No. We are not moving pressures. We are planning health services and thinking about how best to provide health services from the patient's perspective. We receive clear messages from people who use the NHS that they would prefer to be treated at home or in the community, if that is clinically appropriate. Therefore, the issue is designing the right health service. The financial system must follow that rather than drive it.

Mr Raffan: That seems to contradict a remark that you made. You said that services must be provided within the resources that are available—that makes financial pressures king.

Mr Jones: It is a fact of life that no organisation or individual can spend cash that they do not have—at least, they cannot do so for long. I do not think that the Auditor General would be happy with the NHS if we planned to overspend. Therefore, we must provide services within the resources that are available.

Mr Raffan: Health board areas differ in their deficits and surpluses and are under different pressures. That means that medical care and drugs must be rationed and that certain drugs are available in Fife, but not in Forth valley or Tayside. Care of patients is therefore not king.

Mr Jones: Let us take a step back and think about how the NHS is funded. The funding of NHS

boards is based on an assessment of the relative need for health care. The funding is based on need. If one part of the NHS is overspending and another is in balance, one cannot assume that that is because the organisation that is overspending needs those resources. Everyone gets their fair share of the national resource, based on the Arbuthnott formula. We are working with the NHS boards to address the fact that some systems are overspending. If they are receiving their fair share of national resources, they must produce plans to demonstrate how they will provide services to residents using that fair share, otherwise, we will have to take resources from an organisation that is in balance to subsidise the organisation that is not in balance.

The Convener: It might be tempting to talk about policy, but our duty is to steer clear of it. Margaret Jamieson, do you want to pursue this important issue?

Margaret Jamieson (Kilmarnock and Loudoun) (Lab): I think that everybody welcomed the Arbuthnott formula, which was stated in the report "Fair Shares For All", because it meant redistribution. However, our concern about the transfer of funds from acute to primary care is that that transfer is not transparent. We know how central funding for each health board has come about through Arbuthnott funding, but we do not see such transparency at a local level. Would it assist you and us for next time if we could see whether NHS organisations have applied the formula at a local level and what impact that has had on the trust's or health board's deficit?

Mr Jones: The Arbuthnott formula transfers resources to NHS board level. We have anxiety about applying the Arbuthnott formula to smaller population bases as the smaller the population, the less robust the formula becomes. Our view is that the Arbuthnott formula is appropriate at NHS board level. How the health boards distribute that funding between the primary care sector and the acute sector is a matter for them, in line with the local health care plans. We expect the local health plans—which boards produce every year—to be transparent and to show how they use the funding that is available to them, how they split the funding between primary and secondary care and how they use that funding to address national priorities.

Margaret Jamieson: The difficulty is that we politicians are answerable to the electorate. That is difficult in areas of significant deprivation where we cannot get health services delivered despite the fact that there is an over-abundance of services in affluent areas. The difficulty lies in getting that changed. Should financial reporting or another tick box be used to ensure that such areas are coming up to scratch?

Mr Jones: I think that I said that the Arbuthnott formula is not a mechanism that should be used to identify how to address health inequalities. The issue of health inequalities is one of the department's major priorities—it is an element of the performance assessment framework. As part of our monitoring of NHS boards, we will examine how boards address the inequalities in their areas.

The Convener: We are getting close to policy areas in considering the funds that are available to the trusts and boards and how those funds are used. We will move on to consider how NHS trusts are continuing to experience difficulties in achieving their financial targets.

14:30

Mr Lloyd Quinan (West of Scotland) (SNP): I apologise to the committee for my late arrival.

Rather than begin with the question that I had prepared, I will ask about something that Mr Jones mentioned, although I am not sure whether he is able to answer my question or whether the Auditor General should answer it. Mr Jones referred to the Arbuthnott formula as something that is not particularly effective at the small population level. I had not heard that view before. Is there a reference to, or an acknowledgement of, that difficulty with the formula in the Arbuthnott report? Alternatively, was Mr Jones voicing an opinion that has developed among those who have to apply the formula?

The Convener: I will add a question: what effect does that problem have on people who are experiencing difficulty in achieving their financial targets?

Mr Aldridge: The Arbuthnott formula was designed to distribute resources at health board level. I do not think that there is a reference in the Arbuthnott report to the recognition that the Arbuthnott formula would not be robust for very small population levels. It is difficult to judge where the cut-off point comes in, between when the formula is absolutely not robust and when it is robust enough. We stick by Trevor Jones's comment that the smaller the population level, the less robust the formula is likely to be. We are not saying that there is an absolute level below which the formula is not appropriate, but I make the general statement that the lower the population level, the less robust the formula.

Mr Quinan: I refer you to paragraphs 4.5 and 4.6 of the Auditor General's report, which clearly show that eight trusts failed to break even in 2000-01—in fact, those trusts had deficits that totalled £54 million. I accept that one trust had a technical deficit and is therefore excluded, but the overall position has deteriorated fairly seriously. When did your department become aware of the problems that were faced by those trusts? You may

separate out the trust that had a technical deficit.

Mr Jones: I will pick up on the overall figure, while John Aldridge will talk about the specific process for monitoring individual trusts.

You are right to say that the overall deficit was £53.9 million—that figure includes the £12.7 million technical deficit from Lanarkshire Acute Hospitals NHS Trust. On the variation between years, in 2000-01 the deficit rose overall by £11.4 million, and trust surpluses rose by £9.7 million. That brings us back to the net variation of £1.7 million. We have detailed discussions about that issue with each of the NHS boards and with the trusts in each NHS board area. Perhaps John Aldridge could take us through some of those processes.

Mr Aldridge: We are in contact with all trusts every month. We receive monitoring returns from the trusts every month and we are aware that, at various times during the year, the trusts forecast that they will be in deficit or in balance. Their forecasts can vary from month to month, depending on the pressures that hit them. We keep in close contact with the trusts and we have a protocol in place that means that, if a significant deficit is forecast or if there is significant movement from month to month, there is a plan for what we call escalating intervention. That starts with making contact with the organisation concerned, asking for an explanation and, if the explanation is unsatisfactory, taking increasingly robust, interventionist steps to try to help the position.

On the eight trusts that were in deficit in 2000-01, we were aware that, at times during the year, all had been forecasting difficulties. We would not have known the precise amounts of the deficits before the end of the year. Some of the deficits were well known. The Audit Committee is well aware of the Tayside University Hospitals NHS Trust deficit, as the committee carried out its own review of that situation. We were in close contact with Tayside and brought in a task force to try to resolve the position. In other cases, we have made contact and worked with the organisations to develop recovery plans to help them to get back into balance where that was possible. Where it was not possible, we tried to agree a longer-term recovery plan, which would return to balance over time.

Argyll and Clyde Acute Hospitals NHS Trust had a retained deficit of £3.5 million at the end of 1999-2000. At the end of 2000-01, the trust's retained deficit was down to £3 million. That meant that the trust had improved its position over that year.

Mr Quinan: I am sorry to interrupt, but would I be correct in saying that in 1999-2000, Argyll and Clyde Acute Hospitals NHS Trust was given the right to sell a piece of land and to retain the £1.5 million that it received from that sale to set against the deficit that it was carrying at the time?

Mr Aldridge: Yes, I think that that is correct.

Mr Quinan: So, without that non-recurring funding, Argyll and Clyde Acute Hospitals NHS Trust would be facing a deficit this year of £5 million.

Mr Aldridge: Yes, but as we made clear to the committee last year and as continues to be the case, the use of non-recurring money to fund a deficit is acceptable, in our view, if it is part of a longer-term plan to get back in balance.

Mr Quinan: Ultimately, Argyll and Clyde Acute Hospitals NHS Trust will run out of land. The £3 million deficit that the trust is carrying now is the same as the deficit that the trust was carrying in 1999.

Mr Jones: Ultimately, Argyll and Clyde NHS Board must have a financial plan that demonstrates that it can live within its fair share of national resources.

Mr Quinan: That is what I am getting at. Those figures do not tell the full story about Argyll and Clyde.

Mr Jones: Absolutely.

Mr Quinan: The use of non-recurring funding means that the deficit today is the same as the deficit three years ago. However, in the intervening period, to my knowledge, the trust was allowed to retain £1.5 million from the sale of land. I believe that there was also a further amount.

The Convener: You said that surpluses in trusts rose. Could you tell us how many trusts were in surplus, by how much and whether non-recurring expenditure was involved? How did you achieve those surpluses?

Mr Jones: I do not have the figures in front of me. Non-recurring expenditure and income will be involved. Every year, the health bodies have non-recurring items of expenditure and items of non-recurring income. I do not have a statement about what those levels were.

The Convener: Would it be possible to supply us with such a statement at a suitable time?

Mr Aldridge: I am not sure what breakdown we have for individual trusts.

The Convener: You made a general statement that surpluses in trusts rose and I would like that to be delineated.

Mr Jones: We would have no problem in providing a schedule of trusts in surplus and trusts in deficit, showing the net change of £1.7 million.

The Convener: It would be interesting to know the reasons for the surplus. It would give us a better picture if we knew how much of that was a result of non-recurring expenditure.

Mr Quinan: Or the sale of asset land.

I want to refer back to Mr Jones's letter and a point that the convener has just made. Could you explain to me—a lay person—exactly what difference it makes if eight trusts are in deficit and the remaining trusts are in surplus, if there is no ability to transfer that finance?

Mr Jones: Under the new finance regime, there is an ability to transfer resources within NHS board areas. The test should be—this will be part of the new regime—how many NHS boards are in deficit and in surplus, after netting off the tendency for primary care trusts to underspend and the tendency for acute trusts to incur deficits. That is what we will now consider as a measure of performance.

Mr Quinan: Again, I refer you to exhibit 5 in the Auditor General's report, which shows the trusts that did not break even. Which of those trusts, in your opinion, face the greatest problems in achieving break-even in the future, particularly in light of the discussion that we have just had about the use of non-recurring funds in Argyll and Clyde NHS Board?

Mr Jones: We are having discussions with a few boards. We are having regular meetings with Argyll and Clyde NHS Board to examine its financial plan. We are working with Grampian NHS Board, which is developing a longer-term financial plan. We do not have major concerns about Highland NHS Board. Lanarkshire NHS Board has a technical deficit, so we have no problem there. Greater Glasgow NHS Board is reviewing its acute services strategy. The discussions around the Glasgow trusts and the longer-term financial position are part of the overall strategy. At the end of this month, Greater Glasgow NHS Board will consider what progress it can make. The Renfrewshire issue is part of the Argyll and Clyde NHS Board issue that we have mentioned. From my position, things are looking much better in Tayside NHS Board. I am not losing sleep over that situation at the moment as I believe that progress is being made.

Mr Aldridge: I would add only that it would be wrong for us to say that we are not worried about any areas that do not feature in exhibit 5. There are pressures in all NHS areas across Scotland. We keep in touch with the boards that do not feature in the list.

Mr Quinan: If you were a betting man, which trust would you put money on failing to break even in the future? That is the nub of the question.

Mr Jones: I am not a betting man and I would not put money on that. The situation is fluid and pressures can occur and subside. We do not focus on a particular area. At any point in time, we will be having certain discussions with certain areas, but that will vary as issues change.

Mr Quinan: Which areas do you think face the greatest problems in achieving break-even in the future?

Mr Jones: John Aldridge was right when he said that pressure due to something such as a pay award applies equally across the NHS. Some organisations do not figure on the lists that are before us because they manage the pressures within the organisation without a problem. That does not mean that those organisations do not have to make some difficult decisions, however.

I would not forecast which areas will meet particular problems. We need to see the longer-term health care strategies and financial plans for Argyll and Clyde NHS Board, Grampian NHS Board and Greater Glasgow NHS Board. When we get those—and work is being done on them at the moment—I will be more reassured, but I would not say that a particular area gives us particular problems.

Paul Martin (Glasgow Springburn) (Lab): Mr Jones, you told the committee last year that recovery plans were being set up for the trusts that were in deficit. Are you concerned that a number of those trusts have not moved towards a balanced position? Are you certain that the recovery plans are robust and achievable?

Mr Jones: I am concerned that we have not made as much progress on recovery plans as we would have liked to make. However, part of that is to do with the additional pressures that inevitably occur in a system. Some of the cash from planned savings that are being made might have to be spent on those pressures. As John Aldridge is much closer to some of the recovery plans, he might like to answer the question.

Mr Aldridge: It is important to recognise that recovery plans are not fixed in concrete. They develop in the light of pressures that arise and changes that occur. For example, Tayside had serious financial problems but its recovery plan appears to be operating well. The targets in the recovery plan are being met and, so far, progress is good. Other recovery plans in other areas are working more or less well, but where they turn out to be working less well, we intervene and ensure that a revision is made to try to get them back on track.

Paul Martin: Can you name the trusts that you are talking about? You have named one that is doing particularly well, and I am sure that Tayside University Hospitals NHS Trust will be delighted to

hear that. Am I correct in presuming that Glasgow trusts are experiencing specific difficulties in achieving their recovery plans? If a trust is not meeting the recovery plan that has been implemented by the Scottish Executive, in partnership with the trust, are not there management issues relating to that which must be explored further?

14:45

Mr Aldridge: It would be wrong to say that Glasgow's recovery plan was not working. The financial recovery plan for the NHS in Glasgow, which brings together the positions of the various trusts in Glasgow and Greater Glasgow Health Board, will, I think—we cannot be absolutely sure until the end of the year—produce results this financial year. It appears to be reasonably well on track. That is not to underestimate the difficulties that exist for the Glasgow NHS system in delivering that agenda, but it is reasonably well on track. I am not in a position to comment on management issues.

Paul Martin: I would like clarification about the trusts that are not doing well. You were willing to name the ones that are doing well, and that is welcome, but let us focus on the ones that are not doing well.

Mr Aldridge: I think that what I said was that recovery plans work more or less well. It is not the case that any are complete disasters or are not working at all.

Paul Martin: I recall that you stated explicitly that there were trusts that were not doing well. You named Tayside University Hospitals NHS Trust as one that is doing well.

Mr Aldridge: Yes.

Paul Martin: For the benefit of today's evidence session, the committee is entitled to hear you list the trusts that are not doing well. Surely that is a fair question to ask. If you name a trust that is doing well, you should also name one or two that are not doing well.

Mr Aldridge: I would find it difficult to say that any trust or any recovery plan was not doing well. What I can say is that there are some recovery plans about which we are still in discussion with the organisations. As Trevor Jones said, we are still in close discussion with Argyll and Clyde Acute Hospitals NHS Trust and with a number of other trusts, some of which are not featured in the report, where there have been financial pressures. We keep in regular touch with those trusts because we were concerned that performance was not as good as we might have hoped, but I hope that those trusts are coming back on track.

The Convener: What assurances can you give us about sustainability? Sticking to the recovery plans is one thing, but will they work into the future? They could work one year but not the next.

Mr Jones: It is critical to have long-term financial plans that demonstrate that each NHS health board area has a sustainable financial position. As part of their local health plans, the NHS boards must produce a three-year forecast to demonstrate that they can live within their resources, not just in the current 12 months but in the longer term as well.

Mr Raffan: How can you have long-term financial plans when the NHS is under the kind of pressures that are described in paragraphs 4.7 and 5.6? Many of the pressures in the current year will obviously continue well into the future. Perhaps you could comment on some of those pressures, such as slippage in planned cost-reduction programmes, overspends on budgets due to the increasing costs of drugs and new drugs, increasing demands on community services, increasing investment in primary care, and pay awards.

Paragraph 5.6 shows that there is an increasing number of elderly people. The care of elderly people also involves spending on new drugs, gene therapies, pay awards and so on. How predictable are those pressures and the way in which they increase?

Clinical waste is included in the report; it was not included last year. European directives on clinical waste have come, asteroid-like, from nowhere.

Mr Jones: No one can forecast the future, but that is not a reason for not having long-term plans. In fact, it is a reason for having a very detailed planning process. The fact that we live in a world where life is constantly changing reinforces the need to be thinking ahead, planning ahead and forecasting ahead, but we will never be able to forecast the whole of the future. Things will vary.

What we need is a flexible planning system that can react quickly to new developments. New drugs that will cost more will come into the system. Old treatments that are expensive will disappear from the system. Things are constantly changing. Some of those changes will increase costs, whereas others will reduce costs. A strong planning basis is needed so that, based on the best information available, the NHS can be shown to be in sustainable financial balance.

Mr Raffan: I would never for a moment suggest that there should not be plans. I was trying to illustrate how easily plans can be thrown off course. You would probably agree that the treatments that disappear from the system are likely to be replaced by far more expensive treatments. The longer that people live, the higher the cost will be. There are always likely to be new

factors, other than those that are referred to in paragraphs 5.6 and 4.7 of the report. For example, in the past few days we have heard about the cost of hospital-acquired infection and the pressure that that is likely to put on health boards.

Mr Jones: A great deal of work is being done to establish what the future pressures on the NHS might be. A UK-wide exercise, under the chairmanship of Derek Wanless, formerly of National Westminster Bank, is examining the longer-term pressures—over the next 20 years—on the NHS. I am the Scottish representative on the advisory group concerned. The issues that the group is considering are very similar to those that are identified in exhibit 6 in paragraph 4.7 of the report. The group is asking how demography is changing and what impact an aging population, new health technologies and new ways of treating disease, and changes within the work force will have on the service. The group is engaged in a detailed piece of work and is looking 20 years ahead—that is very long-term planning. The report is due to be published in March.

Mr Raffan: What about my point about HAI and its impact on certain health boards in Scotland, particularly in the west of Scotland?

Mr Jones: Over the past year, we have considered issues relating to hospital-acquired infection, including decontamination, and some additional resources have been given to the NHS to enable it to address those issues. Members will be aware that this morning the Minister for Health and Community Care announced a detailed review of some of the issues relating to hospital-acquired infection. The Clinical Standards Board for Scotland was planning to produce a detailed report on the matter by March 2003, but the minister has asked that that report be brought forward. The issue that Mr Raffan raises is very current. I am not in a position this afternoon to say what the outcome of the board's work will be, but over the next six months a great deal of work will be done on issues relating to HAI.

Mr Davidson: I want to ask about some of the basic structures that you use in modelling. I accept that the advisory group to which you referred is considering pressures on the NHS over the next 20 years and that it will produce a predictability model that applies in general terms to the UK population. However, the Scottish health service has to operate with three-year notional budgets. Your financial modelling is based on the funds that you think the minister will give you. It is not very obvious from the Auditor General's report that you are factoring in the demand-led claims on resources of health boards and health trusts. If you are factoring in those claims, how are you doing it? Do you just come up with a Scottish figure and then apply the Arbuthnott formula, or do you examine more closely the demands that are being made?

There is good statistical evidence of how demands are running in the different categories and specialities of each primary and acute trust. Can you clarify for us the mechanics of how you deal with demand-led claims? You will have noticed that many of my colleagues' questions have focused on individual cases that are highlighted by the Auditor General's report. It would be helpful if you could explain how the health department deals with those cases.

Mr Jones: John Aldridge might want to say more about the detail of the forecasting.

We must keep some of the figures in perspective. Of the 28 trusts, eight are in deficit. The deficit in those trusts is £53.9 million, out of a total health budget of £6 billion a year. If surpluses are offset against that deficit—which it is possible to do within health board areas—over the year the NHS was within £1.7 million of breaking even on the budgets in question. That is good financial management. There are issues that need to be tackled in the trusts that are in deficit.

We do not fund the NHS on a demand-led basis. The committee's review of the issues in Tayside highlighted the fact that part of the problem was that services had been developed that were not sustainable and that did not have a sound financial plan to support them. That added huge costs to the system. We believe that the right way to fund the NHS is to allocate resources based on need and then to allow the local NHS board to plan the detailed services within that fair share. The funding of services on a demand-led basis encourages people to start initiatives for which there is no hope that they can be funded locally. That simply puts more pressure on the overall budget.

A deficit in one area can be funded only by taking funding away from a part of the NHS that is managing its resources well. Demand-led funding leads to a spiral of rising costs and does not promote prudence and sensible financial management.

John Aldridge can say more about funding.

Mr Davidson: Let me respond briefly by saying that that might be fine for Scotland as a whole, but the calculations do not appear to include the evidence about the demand for existing core services in parts of the country. I was not talking about new inventions or new therapies and interventions. Perhaps, under the new system, we should conduct those arguments with the health boards. Are you saying that if, in future, the committee wants to investigate deficits, it should pull up health boards rather than your department, which has overall control of only the lump sum?

Mr Jones: No. I challenge the premise that services that are currently provided by an organisation that is overspending are the appropriate services. There is an assumption that they are core services. The data on the 15 health board areas show that only five boards have trusts that are in deficit. A number of the trusts that are in deficit are in the same health board area. For example, two of Greater Glasgow NHS Board's trusts and two of Argyll and Clyde NHS Board's trusts are in deficit.

We allocate resources based on the need to provide health services to a population. We then expect the NHS boards in conjunction with the trusts—the chairmen and chief executives of the trusts are corporate members of their NHS boards—to plan resources within that fair share. Earlier, it was mentioned that drugs are sometimes prescribed in one part of the country that are not available in another area. We need to ensure that we get a fair, affordable health service throughout Scotland, which can be provided within the resources that we have. The vast majority of NHS organisations in Scotland are in financial balance and are providing health services within that fair resource. It would be wrong to offer advantage to those that are overspending, at the expense of those that are managing well.

Mr Raffan: All those terms are so difficult and so subjective. You mentioned a fair, affordable health service throughout Scotland. Perhaps that is a paradox. The difficulty is that new pressures occur in the acute trusts, as we saw in Tayside, where innovative cancer services were developed. The point of Mr Wanless's committee was to examine how to deal with pressures, which—a bit like the universe—are infinite. However, the pressures must somehow be capped. I love your phrase

"a fair, affordable health service throughout Scotland,"

but perhaps such a thing is not fair. The estimate is made by your department. Somebody must do it, I suppose.

Mr Jones: You might be challenging the Arbuthnott formula.

Mr Raffan: I had better not stray into policy.

Mr Jones: In the past, we have all had views about Arbuthnott, but most people recognise that the Arbuthnott formula uses indicators that acknowledge the need for health expenditure. The indicators take account of the make-up of the population in terms of age and sex, and of issues of deprivation. The formula also takes account of the rurality issues that Scotland faces. The Arbuthnott formula is the best that we have got.

Mr Raffan: I will ask about clinical negligence.

The Convener: Before Mr Raffan moves on to a different territory, I want to ask a further question. I am still concerned about what we are asking trusts and boards to do, given their lack of overall resources.

In exhibit 6 of the Auditor General's report, the main reasons for trusts' deficits come under four general headings. However, two and a half of the reasons that are given are out of the trusts' hands. Perhaps the trusts could have done something to make more savings, but budget overspends that arise from the increased cost of drugs and surgical equipment tend to be out of their hands. Increasing demands on community services are completely out of their hands and so are pay awards.

It bothers me that we are asking trusts to break even or to use those resources. Are resources adequate to meet increasing demands? If some of the main factors behind trusts' deficits are out of their control, how fair is it to ask them why they are not balancing their books?

15:00

Mr Jones: Of the 28 trusts, 20 were able to deliver resources within their budgets. Each trust faces exactly the same set of pressures. Not every trust is in deficit because of the four main reasons that we have discussed, although it is correct to say that those factors put pressures on the NHS system.

As new drugs are developed, we require a process whereby drugs that prove to be effective are introduced in a uniform way throughout Scotland in order to avoid postcode prescribing. The Health Technology Board for Scotland is now building up a head of steam on such matters, and it is considering management of the introduction of such drugs.

Obviously, the cost of pay awards must be met, and those awards cannot be controlled within trusts. We should examine the increase that we give the NHS boards and trusts each year for inflationary increases and whether that is adequate to meet the cost of pay. Generally, most NHS organisations are within budget, and face exactly the same set of pressures.

I want to pick up on an important point that was raised earlier. As was rightly mentioned, some teaching organisations figure on the list of organisations that have deficits. It is fair to say—although this might be a subjective view—that pressures tend to hit some of the teaching organisations a wee bit more than they hit some other organisations.

Mr Raffan: "A wee bit more"?

Mr Jones: It is quite difficult to see any hard evidence, so I am being very careful in what I say.

We are picking up some of those differences in terms of the new financing regime, with regard to which we are thinking about how regional specialties are developed. We are consulting the NHS about a new way of funding the teaching elements of the service. We hope that that will improve the position of teaching organisations, that it will allow for a wee bit more control over how services are introduced and that it will improve the mechanism to fund them, using all the boards that use the teaching hospitals.

The Convener: We have inadvertently strayed into a different area, which is the detailed examination of finances.

Margaret Jamieson: I want to comment on Mr Jones's point about regional services. There is a problem with determining what is and what is not a regional service. That might have an adverse effect in certain NHS board areas; I cite greater Glasgow. To take the example of rheumatology, we in the west of Scotland believe that Greater Glasgow NHS Board provides a regional service, but it is not funded accordingly. The boards in the surrounding areas contribute to the deficit in greater Glasgow. It would be helpful to hear your thinking on that and on what impacts it might have on the accounts of the various trusts.

Mr Aldridge: The consultation to which Trevor Jones referred includes a definition of what will count as a regional service for a regional specialty for the purpose of the new arrangements. We have attempted to define regional services fairly tightly because it is important to leave sufficient local flexibility with health boards, so that all their discretion is not taken away from them.

The new system attempts to move away from the arrangement whereby a teaching trust, for example, must negotiate with half a dozen, seven or eight health boards for separate amounts of money to pay for the service that it provides to those boards. Instead, we propose—broadly—that there be regional consortiums, which would agree on the cost of the service and on what uplift is required each year to continue to provide it. Then, the agreed cost would be allocated among the appropriate health boards and the resources would be transferred from the health boards to the host health board, so that there is one kind of stream of money going to the trust instead of having seven or eight negotiations—

Margaret Jamieson: That could lead to other difficulties, as we have seen in relation to cancer services, in which transparency is lacking. Money goes from the individual board areas, but we do not see it being directed to the service for which we pay. How will you deal with that? Could we get a copy of the consultation that Mr Jones issued?

Mr Aldridge: We are happy to send you a copy of the consultation paper.

The agreement must include clear ring-fencing arrangements so that the resources that are provided for a regional service go to that regional service.

Mr Raffan: I will go on to criminal negligence provision. You sent us a letter, dated 16 January, in advance of giving evidence today, in which you mentioned our "helpful suggestion" last year of a review of criminal negligence provision.

Margaret Jamieson: You mean "clinical".

Mr Raffan: I am sorry—clinical negligence provision. Will you tell us how that review is progressing? What changes are likely? You say in your letter that you are still collecting information from the trusts. When do you expect to reach a conclusion?

Mr Aldridge: Information is still coming in from the trusts. The evidence that we have so far suggests that there is over provision. In general, the amount that must be paid out on a specific criminal—now I am saying it—clinical negligence claim is somewhat less than the provision that is entered in the accounts. We must wait until we get the rest of the information before we can determine the precise amount of that excess. It is not as much as a third, but it is significant.

Mr Raffan: Last year, the level of settlements doubled but the rate of increase is coming down. By how much is it coming down?

Mr Aldridge: The amount of money that was paid out in 2000-01 was £6.5 million. The average in previous years was about £4 million. It is not yet clear whether that was a blip or a general trend. The number of claims that are lodged has been coming down from year to year in recent years.

Mr Raffan: What has happened to the value of those claims or the likely possible settlement?

Mr Aldridge: The value of the claims remains fairly constant. However, some earlier claims have been revalued upwards because of the time that they have been in the system. That has led to an increase in the provision that has had to be made.

The information that we are collecting from the trusts suggests that a reduction in the provision might be possible. We must try to determine by what amount it could be reduced during the rest of the financial year.

Mr Raffan: When do you expect to make a decision on that?

Mr Aldridge: We hope to do it before the end of the financial year; that is, before the end of March.

Paul Martin: I will revisit non-recurring funding, on which we touched earlier. Mr Jones and—I

think—Mr Aldridge stated that they did not have any concerns about trusts using those funds to reduce their deficits. Am I correct?

Mr Jones: Yes.

Mr Aldridge: We agree with such use when it is part of a plan that will lead to recurrent balance in due course.

Paul Martin: Do you disagree with paragraph 4.8 of the Auditor General's report, in which he states:

"This remains a significant issue for NHSScotland"?

What are your views on that?

Mr Jones: As long as non-recurrent funding is used as part of a long-term financial plan, it is an appropriate use of resources. You must remember that health board and trust expenditure includes non-recurrent items of expenditure. Some of the expenditure is non-recurrent; some of the income is non-recurrent. As long as the non-recurrent income forms part of a robust, long-term financial plan, its use is appropriate.

Mr Aldridge: I do not disagree with the Auditor General that it is a matter of concern if non-recurrent funding is relied upon too much. Such funding, by its nature, can vary from year to year.

Paul Martin: Yes—but the Auditor General says that it is a significant issue for Scotland as a number of trusts are breaking even because they are using that method of funding.

Mr Jones: The critical issue is for the trusts to have long-term financial plans.

Paul Martin: North Glasgow University Hospitals NHS Trust has a deficit of £9.3 million. Earlier, we heard that Argyll and Clyde Acute Hospitals NHS Trust had £1.5 million of estate land available to it. If North Glasgow University Hospitals NHS Trust was able to identify £8 million of estate land, would that help it to reduce its deficit?

Mr Jones: If a trust had a plan that would allow it to operate within available resources, but which needed short-term financial support to allow it to happen, that would be a reasonable way in which to use non-recurrent incomes. However, it would be unreasonable of me to talk about a particular trust.

Paul Martin: If a number of trusts do not have estate land available, will that lead to unfairness? If North Glasgow University Hospitals NHS Trust does not have estate land, but another trust does, does an issue of parity arise? It is obviously unfair if one particular trust has a wealth of estate land available to it, which it is able to use to reduce its deficit. How does the Scottish Executive deal with parity?

Mr Jones: I guess that the real issue is the extent to which we should control the NHS from the centre. We could pool all non-recurrent windfall gains—from, for example, land sales—and then arbitrate over the use of that money. Another option would be to give the local NHS boards the flexibility that would allow them to manage their own estate for the benefit of local people. We tend to allow local NHS boards to manage their own affairs. They must consult us when they have a major land sale receipt, but we tend to allow them to manage their own estates. If we did otherwise, we would take away any incentive to use the NHS estate well. If trusts made radical decisions to do with rationalising estate, and then saw the cash disappear into a central black hole, they would not feel any incentive to manage that resource well.

The Convener: I want to ask about clinical negligence claims. Is your review aimed simply at reducing the total amount on an actuarial basis of the likely extent of claims, or will it consider the causes of claims?

Mr Aldridge: The review is to do purely with the provision that is made in the accounts. The clinical negligence and other risks indemnity scheme is designed not only to provide a funding pool for claims, but to encourage and incentivise NHS organisations in Scotland to manage their risks, to identify the causes of clinical negligence claims and to take action to prevent them from happening again. We are not ignoring causes, but we are dealing with them differently.

The Convener: With higher standards, there will be fewer claims.

Mr Aldridge: That is the intention.

The Convener: We will move on to consider the impact of the £90 million of additional funding for the NHS that was announced by the Minister for Health and Community Care in 2001.

Mr Quinan: The £90 million of additional funding—in particular the part that was earmarked for Tayside—was required to wipe the slate clean and give a new start. I go back to a question that has been asked three times: in the next couple of years, who will be the next Tayside? Based on their current deficits, their community profiles and—to pick up on an issue that was raised by Margaret Jamieson—their relationships with surrounding health boards to which they provide services, which of the trusts or boards will, in your judgment, face the greatest problems in breaking even?

Mr Jones: My answer has not changed from the answer that we gave earlier. All NHS boards and trusts face the same challenges. It would be wrong to say that one board or trust has a more—

Mr Quinan: I appreciate fully what you are saying, Mr Jones, but, at this stage, you really must be able to describe the situation. Let us consider the changes in Greater Glasgow Primary Care NHS Trust and the continuing deficit in Argyll and Clyde Acute Hospitals NHS Trust, in Renfrewshire and Inverclyde Primary Care NHS Trust and in the other associated trusts around the Greater Glasgow NHS Board area. They are all in deficit. Glasgow is in deficit. I do not want to pre-empt the review, but it does not take a genius to see that the current circumstances in hospitals in the south of Glasgow and the existing deficit in North Glasgow University Hospitals NHS Trust indicate that the next problem—similar to what happened in Tayside—might happen in Greater Glasgow NHS Board. Do you agree?

15:15

Mr Jones: I disagree with that. When we get to the end of this financial year, my feeling is that the NHS in Glasgow will be close to breaking even. I repeat that we examine the whole system. By the end of this financial year, I hope that Greater Glasgow NHS Board will have agreed its views about the future of acute services in greater Glasgow. Implementation of that will be a challenge. The task in Lothian NHS Board—in terms of managing health services for its population—is no easier than that which faces the people who manage the affairs of the Greater Glasgow NHS Board.

Mr Quinan: Are you prepared to accept that it would be in the interests of the Audit Committee, the Auditor General and you to give us an amber light on which trust it is likely to be? To do so would not condemn those trusts or boards to a definite deficit, but it would be useful to flag any problems up. From the Tayside inquiry, we know that if problems had been flagged up earlier, the situation might not have become so bad.

Mr Jones: I said earlier—my position has not changed—that we should not look narrowly at issues around finance and the forward plans. However, members must remember that managing the NHS is more than getting right the financial bottom line. I said earlier that we are holding detailed discussions with Argyll and Clyde NHS Trust. We need to see what will be its long-term solution for its service plans. We are holding similar discussions with Grampian NHS Trust. Those discussions are at a more advanced stage, but they also pose challenging questions.

At the end of the month, we will reach a major milestone with Greater Glasgow NHS Board, when we discover whether—as a result of the exercise—there is a long-term service strategy for greater Glasgow. That said, we should not assume that everything is rosy in everybody else's garden—real challenges must be addressed.

Mr Quinan: Thank you very much. I—

Mr Jones: We should not imply that the challenge is going to be more difficult in those areas.

The Convener: Lloyd Quinan has asked his question tenaciously and he has received an answer. Do you want to raise any additional points, Lloyd?

Mr Quinan: I will add a straightforward question on the £90 million additional funding. Will you say something about monitoring of those additional funds and about how you can ensure that the funds are used to eliminate trusts' accumulated deficits, rather than to finance additional services?

Mr Aldridge: The figure of £90 million contains various elements, which are being monitored in different ways. We can be sure that the amount that is distributed to clear the accumulated deficit will achieve that. If any trust that has a cumulative deficit runs a deficit this year, the deficit that emerges this year will be included in the books at the end of the year. We have instructed the boards concerned to use the resources to clear the accumulated deficits in the trusts that had such deficits as at March of last year.

In addition, £11 million was distributed to enhance winter planning arrangements in the NHS throughout Scotland. Over the winter that distribution, and the wider winter-planning arrangements that NHS boards have put in place, are being monitored weekly. The balance of resources was distributed to NHS boards for use at their discretion to deal with in-year pressures and—if it is affordable and sustainable—to create new developments.

Mr Quinan: Do you mean development of services?

Mr Aldridge: If those services can be sustained.

The Convener: That is £79 million to provide a clean slate—including £11 million to Tayside—out of the additional £90 million.

Paul Martin: We touched on the fact that the trusts that failed to achieve break-even in 2000-01 had accumulated deficits totalling more than £54 million. Assuming that those deficits have been eliminated by the additional funds, and that the £11 million set aside to help to prepare for winter pressures has been used for that purpose, how has the balance of the £90 million—£25 million—been applied?

Mr Jones: I do not have that information.

Mr Aldridge: As I said, the balance of resources was distributed to help the NHS boards. Its use was left largely to their discretion. The guidance

that was issued to boards was that the money should be used to deal with any financial pressures that they might face and, in particular, to minimise any in-year deficits that might occur. Beyond that, the money was to be used to meet local pressures, and for initiatives and developments, if they could be sustained in the longer term.

The Convener: We are talking about £25 million. How was it distributed? What rationale was used?

Mr Aldridge: Other than the special amount for Tayside, the resources were distributed broadly on the basis of the Arbuthnott formula.

Mr Davidson: I want to follow up on the point about trust deficits, because we are concerned about that issue. The phrase "accumulated deficit" is used regularly. However, the trusts talk about agreed deficits. I gather that some of those agreements were just for the current financial year. It would be helpful if you could define what the trusts consider to be agreed.

That leads me to another serious issue. To accept agreed deficits means that we accept that there are structural deficits in certain organisations within the health service. Will you clarify whether, in strict accountancy terms, there are such things as structural deficits? That seems to be how the health department wants to answer questions today. If there are, what plans do you have to remove them instead of carrying out an annual retrospective cleaning-the-slate exercise? That is not exactly the way for the NHS to forward plan the use of resources.

Mr Aldridge: I am not sure which trusts you have in mind when you talk about agreed deficits. I know of two sets of circumstances where recovery plans are in place: Tayside University Hospitals NHS Trust and Grampian University Hospitals NHS Trust. As part of those recovery plans, the trusts have forecast that they will work to produce a certain level of deficit in the current financial year. That is part of a longer-term plan to eliminate the deficit over a longer period.

Those deficits can be called agreed deficits in the sense that we have said that if the trusts achieve what they have promised to achieve, we will not regard that as a failure. In the case of Tayside, that is a deficit of no more than £4 million and in Grampian, no more than £6 million. Those deficits are part of longer-term plans to return to recurrent balance, but they are not agreed in the sense that we are prepared to see them continue indefinitely.

Mr Davidson: So you are saying that structural deficits, in pure accountancy terms, do not exist. They are a temporary blip in the health service.

Mr Aldridge: Yes.

Mr Davidson: That bears no relationship to the trusts' attempts to meet the basic service requirements of their area.

Mr Aldridge: In the case of the two trusts to which I referred, Tayside and Grampian, one of the factors that we took into account when agreeing the recovery plans, which forecast an in-year deficit in the current year, was the need to maintain service standards. To that extent, there is a link.

Mr Davidson: I judge from Mr Jones's earlier comments that in-year progress reports and monitoring go on all the time.

For 2000-01, £68 million was used to clean the slate. Will similar additional funding have to be offered again at the end of the current year?

Mr Aldridge: We currently have no intention of doing so. I would be reluctant to do that again. The resources that were issued to clear accumulated deficits were clearly described as a one-off to give the new NHS boards a clean slate. From now on, we intend the arrangement to be as it ought to be: if a deficit is run up one year, it will have to be paid back in future years.

Mr Davidson: You appear to be saying that the money was a non-recurring payment, regardless of whether the circumstances appear again, and that it will not be the solution next time round. Does that mean that you are prepared to renegotiate the deficit payback? Will you agree terms with the various boards, or will you put pressure on the boards that are in surplus and which have trusts that are in deficit to tidy their accounting procedures internally? If so, what steps will you take and what financial controls will you enforce from the centre to ensure that that happens?

Mr Jones: We expect NHS boards to try to solve problems internally. That is part of the system. We monitor that by examining the overall performance of the NHS board and its constituent trusts as a single unit. When we have monitoring meetings, the chairmen and chief executives of the trusts and the NHS board are brought together in the same room. We expect them to operate as corporate board members of the NHS board to solve the problem, not as individuals who represent a specific part of the NHS system.

Mr Davidson: Have you put additional procedures in place to ensure that we pull all aspects of the NHS into balance by 2002-03?

Mr Jones: Remember that, overall, the NHS was in balance in 2000-01. Pockets of the NHS had deficits, but those were matched by surpluses elsewhere. The financial performance of the NHS was remarkable. I repeat that there was a £1.7

million overspend among all the trusts in Scotland, on a health department budget of £6 billion and a trust budget of £5 billion. The NHS is in a very healthy state. There are pressures, which must be managed, and people must take difficult decisions but, overall, NHS Scotland is in a very strong financial position.

Mr Davidson: Moneys are voted for health care in the round—obviously a board has to deal with that as well. Are you satisfied that moneys that were given to other agencies to supplement the activity of the NHS in the community are properly accounted for and have been spent as was originally agreed?

Mr Jones: Which types of expenditure?

Mr Davidson: Let us take a primary care trust as an example. You mentioned care in the community. Money is sent from the NHS pot, via local authorities, to deal with post-medical care or whatever. How do you monitor that? The allocations from the NHS budget involve more than boards and trusts. Are you satisfied that the same rules, regulations and outcomes that apply to internal NHS bodies apply to other bodies?

Mr Jones: Consider the sums that are transferred from the NHS to local authorities under the resource transfer mechanism, which supports the care in the community policy. Each NHS board requires the local authority to produce an audited statement of expenditure that is transferred under the resource transfer arrangements. A formal mechanism is in place to demonstrate that the cash was spent for the purpose for which it was given.

When we transfer cash to local authorities—for example, the cash that was transferred to local authorities directly, rather than by the NHS, to ease the pressure on blocked beds last winter—the financial monitoring arrangements are different from those for the NHS, because the Executive controls the NHS much more directly. The money is controlled as part of the monitoring of local government expenditure, rather than as part of the NHS. If the money is transferred from the NHS, an audit statement is produced.

Mr Davidson: Does your department play any role in that, since it obviously supports the primary care trust?

Mr Jones: It is part of the Executive's monitoring. The management of local authorities is not part of the health department's function.

Mr Davidson: So only the moneys that are directly transferred from health boards are involved.

Mr Jones: Yes. Under the resource transfer initiative, there is a requirement that the NHS board receives an audit statement from the local authority.

Mr Raffan: I have a question, which arises out of your letter to the committee of 16 January, about the management of primary care payments, which amount to 20 per cent of the NHS budget. There is a need for robust verification procedures. There seems to be a difference of view, or at least a difference of emphasis, between you and the Auditor General on the importance of visits to general practitioners as part of the verification procedure. We went into that matter in detail last year. Why does your view differ from that of the Auditor General—and, as I understand it, the committee—that there is a need for more visits to GPs to ensure robust verification?

15:30

Mr Jones: Our process for visits to primary care practitioners was agreed by the Common Services Agency, the NHS boards and the primary care trusts. The information is shared with the Auditor General. There is not a huge difference of opinion between the Auditor General and me, but I question the value for money that we receive for a significant number of the visits to GPs. When one compares the cost of those visits with the errors that are identified, one sees that they may not offer best value. The issue is how regular the visits should be, not whether there should be visits—of course there should be visits. Given the way in which the procedure has developed, I guess that the Auditor General and I are probably closer than we were 12 months ago.

Mr Raffan: Primary care payments are a huge proportion of the NHS budget, so it is important to ensure that they are made accurately and that there is no fraud.

Mr Jones: A controlled procedure should be in place, but we must review the benefit that we receive from the checks, taking into account the number of errors that are detected. We must think about best value and consider the frequency and regularity of visits.

The Convener: I remind members that we will return to the subject of primary care. I allowed the question because it related to the letter that we received from Trevor Jones.

Margaret Jamieson: The issue relates not only to general practitioners, but to dental services and opticians. In a recent episode in Ayrshire and Arran Health Board, the public purse was stung for a considerable sum of money and individuals had dental treatment that they did not require. The issue is two-pronged. The public must know that the people who deliver services are up to scratch and that they will receive the treatment that they should receive. The issue is not only financial, which is one of the Auditor General's points.

Paul Martin: How many verification visits were made to dentists?

Mr Jones: I do not have that information.

Mr Aldridge: I suspect that in the year covered by the report, there were no visits to dentists. Trevor Jones referred to the new procedures. The new agreement on payment verification procedures is not only about visits, but about the range of payment verification procedures. As part of the new procedures, it is intended that visits to GPs, dentists, opticians and other primary care practitioners will be focused and will be undertaken primarily when the other stages of the verification process identify a cause for concern. There will also be random visits.

The Convener: We will return to the issue in detail. The committee would appreciate it if the witnesses would supply a specific answer to Paul Martin's question.

The final questions are on the steps that are being taken to ensure a more comprehensive picture of the financial position in the new NHS board areas and in the NHS in Scotland overall.

Margaret Jamieson: This is the second year that we have considered the overall report and it is still far from comprehensive. It is cloudy in some areas. Like a number of my colleagues, I have difficulty understanding why there is a deficit when there is an underspend in the cash limit. In ordinary lay terms, the figures do not add up.

If members of the committee cannot understand the calculation, I do not hold out much hope of individuals in health board areas being able to do so, even if they look at their local trust's accounts. Will you clarify for us what you regard as the true overall financial position of the NHS in Scotland?

Mr Jones: When you refer to the difference between the cash limit and expenditure, are you asking about which method of control we should use?

Margaret Jamieson: There are so many different methods. You and your department report in one way, the NHS health boards—as they were—report in another way, and the trusts report in a third way. When will we get the fourth way that will tie it all together?

Mr Jones: We have done that. We now account for the NHS on an income and expenditure basis. We are moving away from the old cash controls to what is called resource accounting. We want to ensure that we consider not only how much is in the bank account at the end of the financial year, as cash accounting does. Resource accounting assesses whether we are living within available resources, irrespective of whether we have paid the bills at 31 March. Resource accounting will help us to get a much better feel for the NHS's overall financial position.

Margaret Jamieson: I am not concerned about the feel of the financial position. I want to ensure that the financial position is transparent and that we do not have situations that might cloud the issues. For example, health boards could provide moneys from their cash limits, while remaining within the limits, which enable trusts' figures to look good because they do not appear to be in deficit. That concerns me. I have no evidence that it happens, but if I can think of it, I am sure that there are people in NHS Scotland who could be operating like that. That would make it difficult for us to track down what exactly is happening. My suspicion that that accounting practice goes on would be removed if we had only one method and one accountability mechanism.

Mr Jones: That is right. I have said several times that we consider the overall performance of an NHS board area. We expect all organisations within a board area to demonstrate that they have financial plans that will allow the local NHS system to be in financial balance. The financial situation should be transparent. The overall financial plan should be part of the local health plan and should be a public document.

Margaret Jamieson: Will your proposals be up and running by 1 April 2002?

Mr Aldridge: The new financial regime will operate from 1 April 2002; 2002-03 will be the first year in which the new arrangements will operate throughout the year. We will be part of the way towards that for the current financial year, 2001-02, because, as Trevor Jones explained, trusts and boards—and the Executive—will report for the first time on an income and expenditure resource basis, rather than some bodies reporting on a cash basis and some on an income and expenditure basis. There should be progress on the transparency of accounts for this financial year, but the full picture will not be available for another year.

Margaret Jamieson: So the accounts will meet the consistency claim this year, but perhaps not full transparency.

Mr Aldridge: Yes.

Margaret Jamieson: On the accountability review, what emphasis will be placed on working in partnership to achieve the financial framework?

Mr Jones: Last year, we described briefly the new accountability framework, which assesses all of an NHS board's business. In addition to assessing the NHS board's financial performance, the accountability framework assesses how the board addresses inequalities and improves access to services, and considers clinical governance issues. We also review whether an NHS system is

working coherently.

We want to ensure that the new NHS boards are effective and that all players around the table are striving towards the same set of goals and are delivering accordingly. That will be an important part of the accountability review meetings.

Margaret Jamieson: When will they start?

Mr Jones: The first meetings will be in May and they will run until July.

Margaret Jamieson: How open and accountable will they be?

Mr Jones: We will produce a report. A letter to the NHS board will summarise the review meeting's discussions. That will be part of the NHS board's public meeting and so will be a matter of public record.

Margaret Jamieson: After how many months of lying in a drawer?

Mr Jones: I hope that the reports will be made public very quickly.

The Convener: We have exhausted our questions. Do you want to make a final statement?

Mr Jones: No. We, too, are exhausted.

The Convener: I thank Mr Jones and Mr Aldridge and their staff for their attendance.

I remind everyone that this is only the first part of this investigation and that we shall consider acute and primary care situations in more detail.

We now move into private session, but we will pause to allow witnesses and the public to leave the chamber.

15:40

Meeting continued in private until 15:59.

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